General Assembly

Raised Bill No. 6606

January Session, 2003

LCO No. **3972**

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING PHARMACY BENEFIT MANAGEMENT PLANS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2003*) As used in sections 1 to 10, inclusive, of this act:

(1) "Commission of Pharmacy" or "commission" means the Commission of Pharmacy appointed under section 20-572 of the general statutes;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Cosmetic" means cosmetic, as defined in section 21a-92 of the general statutes;

(4) "Department" means the Insurance Department;

(5) "Device" means device, as defined in section 21a-92 of the general statutes;

(6) "Drug" means drug, as defined in section 21a-92 of the general statutes;

(7) "Enrollee" means a person eligible to receive benefits under a health benefit plan;

(8) "Equivalent drug product" means a drug product which has the same established name, active ingredient, strength or concentration, dosage form, and route of administration and which is formulated to contain the same amount of active ingredient in the same dosage form and to meet the same compendial or other applicable standards, such as strength, quality, purity and identity, but which may differ in characteristics such as shape, scoring, configuration, packaging, expiration time or date, and excipients, including, but not limited to, colors, flavors and preservatives;

(9) "Manufacturer" means a person, whether within or outside of this state, who produces, prepares, cultivates, grows, propagates, compounds, converts or processes, directly or indirectly, by extraction from substances of natural origin or by means of chemical synthesis or by a combination of extraction and chemical synthesis, or who packages, replicates, labels or relabels a container, under such manufacturer's own or any other trademark or label, any drug, device or cosmetic for the purpose of selling such items;

(10) "Insolvent" or "insolvency" means a financial situation in which, based upon the financial information required pursuant to sections 1 to 10, inclusive, of this act for the preparation of the pharmacy benefits manager's annual statement, the assets of the pharmacy benefits manager are less than the sum of the manager's liabilities and requires reserves;

(11) "Person" means person, as defined in section 38a-1 of the general statutes;

(12) "Pharmacist services" includes (A) drug therapy and other patient care services provided by a licensed pharmacist intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, and (B) education or

intervention by a licensed pharmacist intended to arrest or slow a disease process;

(13) "Pharmacist" means an individual licensed to practice pharmacy under section 20-590, 20-591, 20-592 or 20-593 of the general statutes, and who is thereby recognized as a health care provider by the state of Connecticut;

(14) "Pharmacy" means a place of business where drugs may be sold at retail and for which a pharmacy license has been issued to an applicant pursuant to section 20-598 of the general statutes;

(15) "Pharmacy benefits manager" or "manager" means any person that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health benefit plan on behalf of plan sponsors such as self-insured employers, insurance companies, labor unions and health care centers;

(16) "Pharmacy benefit management plan" or "plan" means an arrangement for the delivery of prescription services or pharmacist services in which a pharmacy benefits manager undertakes to provide, arrange for, pay for or reimburse any of the costs of prescription services for an enrollee on a prepaid or insured basis which (A) contains one or more incentive arrangements intended to influence the cost or level of prescription services between the plan sponsor and one or more pharmacies with respect to the delivery of prescription services, and (B) requires or creates benefit payment differential incentives for enrollees under contract with the pharmacy benefits manager. "Pharmacy benefit management plan" or "plan" does not include an employee welfare benefit plan unless it is administered through a pharmacy benefits manager; and

(17) "Wholesaler" or "distributor" means a person, whether within or outside of this state, who supplies drugs, devices or cosmetics prepared, produced or packaged by manufacturers, to other

wholesalers, manufacturers, distributors, hospitals, prescribing practitioners, as defined in section 20-571 of the general statutes, pharmacies, federal, state or municipal agencies, clinics or any other person as permitted under subsection (h) of section ____. "Wholesaler" or "distributor" does not include: (A) A retail pharmacy or a pharmacy within a licensed hospital which supplies to another such pharmacy a quantity of a noncontrolled drug or a schedule III, IV or V controlled substance ordinarily stocked by such pharmacies to provide for the immediate needs of a patient pursuant to a prescription or medication order of an authorized practitioner, (B) a pharmacy within a hospital which supplies drugs to another hospital or an authorized practitioner for research purposes, or (C) a retail pharmacy which supplies a limited quantity of a noncontrolled drug or of a schedule II, III, IV or V controlled substance for emergency stock to a practitioner who is a medical director of a chronic and convalescent nursing home, or a rest home with nursing supervision or of a state correctional institution.

Sec. 2. (NEW) (*Effective October 1, 2003*) (a) Each pharmacy benefits manager that provides a pharmacy benefit management plan to a resident of this state shall obtain a license from the Insurance Commissioner and shall file an annual statement with the Insurance Commissioner on such form as the commissioner may prescribe. The annual statement shall include: (1) A financial statement for the pharmacy benefits manager's organization, including its balance sheet and income statement which shall include all identified sources of revenue for the preceding calendar year; (2) the number of individuals enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year; (3) any other information related to the operations of the pharmacy benefits manager required by the commissioner; and (4) a copy of a certified annual audit performed by an independent certified public accountant for the most recent ____ year.

(b) Such pharmacy benefits manager shall (1) pay all fees, taxes and charges required by law; (2) maintain the minimum capital and

surplus required by the commissioner; (3) file any financial statement or report, certificate or other document that the commissioner deems necessary to obtain a full and accurate knowledge of the manager's affairs and financial condition; (4) maintain solvency; (5) maintain a financial condition, method of operation and manner of doing business sufficient to satisfy the commissioner that the manager can meet its obligations to all enrollees; (6) comply with all requirements of law; and (7) obtain a certificate of license to practice pharmacy from the Commission of Pharmacy.

(c) A nonrefundable application fee required in section 38a-11 of the general statutes, as amended by this act, shall accompany each application for a pharmacy benefits manager license submitted to the commissioner. The commissioner shall use the amount of such fees solely for the purpose of regulating pharmacy benefits managers.

(d) Each pharmacy benefits manager that offers a pharmacy benefit management plan shall obtain and renew its license as a pharmacy benefits manager. The commissioner may refuse to reissue a license or may place restrictions on the license of any pharmacy benefits manager if the commissioner finds the manager lacks required capital or surplus or if the commissioner finds that the manager has not satisfied the requirements of this section, except that prior to refusing to reissue a license, the commissioner shall provide the manager with ten days written notice and shall give the manager an opportunity to be heard at an informal hearing held by the commissioner or a designee. The manager may waive the right to such notice and hearing.

Sec. 3. (NEW) (*Effective October 1, 2003*) (a) Each pharmacy benefits manager that offers a pharmacy benefit management plan in this state shall obtain a certificate of license to practice pharmacy from the Commission of Pharmacy and shall (1) provide proof to the commission that the pharmacy benefits manager is operating in accordance with its basic organizational document; (2) pay all

applicable fees; (3) maintain its certificate of license to practice pharmacy in this state; (4) pay any certificate and license renewal fees to the Department of Consumer Protection or the commission, as the case may be; (5) maintain its license from the Insurance Department pursuant to section 2 of this act; (6) pay pharmacies or pharmacists for pharmacists' services a ten per cent rebate for each drug or device dispensed through the plan to ensure proper education and safe prescription practices for the patient; (7) pay pharmacies and pharmacists a reasonable dispensing fee as determined by an independent cost of dispensing survey to ensure safe prescription practices; (8) pay pharmacies' transmittal costs; and (9) reimburse to the pharmacy at a rate of fifty per cent any funds generated from the selling of aggregate patient information whether specific or nonspecific.

(b) The Commissioner of Consumer Protection and the commission shall use the amount of any fee collected from a pharmacy benefit manager solely for the purpose of regulating pharmacy benefits managers.

Sec. 4. (NEW) (*Effective October 1, 2003*) Each pharmacy benefits manager that contracts with an approved pharmacy or pharmacist to provide services through a pharmacy benefit management plan for enrollees in this state shall file such contract with the Commission of Pharmacy at least thirty days before the execution of the contract. The contract shall be deemed approved unless disapproved by the commission not later than thirty days after the contract is filed. The commission shall adopt regulations, in accordance with chapter 54 of the general statutes, to develop formal criteria for the approval and disapproval of pharmacy benefits manager contracts.

Sec. 5. (NEW) (*Effective October 1, 2003*) Except as otherwise required by subdivision (6), (8) or (9) of section 3 of this act, no person may (1) pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any contract, rebate, special favor or other

benefits, for switching to an equivalent or therapeutic drug product, unless the contract is filed and approved by the Commission of Pharmacy at least thirty days before execution of the contract; or (2) receive or accept any rebate or any special favor or advantage of any valuable consideration or inducement not specified in the contract.

Sec. 6. (NEW) (*Effective October 1, 2003*) (a) No pharmacy benefits manager or its representative may cause or knowingly permit the use of (1) any advertising or solicitation that is untrue or misleading, or (2) any form of evidence of coverage that is deceptive.

(b) No pharmacy benefits manager that is not licensed as an insurer may use in its name, contracts or literature (1) the word "insurance", "casualty", "surety" or "mutual", or (2) any other words descriptive of insurance, casualty or surety business or deceptively similar to the name or description of any insurance or fidelity and surety insurer.

(c) No pharmacy benefits manager may discriminate on the basis of race, creed, color, gender or religion in the selection of pharmacies for participation in a plan operated by the manager.

(d) No pharmacy benefits manager may unreasonably discriminate against a pharmacy or pharmacist when contracting for pharmacy or pharmacist services.

(e) No pharmacy or pharmaceutical manufacturer may own an entity that operates as a pharmacy benefits manager.

(f) No pharmacy benefits manager may discriminate when contracting with pharmacies on the basis of copayments or days of supply.

(g) No pharmacy benefits manager may discriminate when advertising which pharmacies are participating pharmacies. Any list of participating pharmacies shall be complete and all inclusive.

Sec. 7. (NEW) (*Effective October 1, 2003*) Each pharmacy benefits

manager shall provide the following information to enrollees in its plans at the time of enrollment or at the time the contract is issued, and shall make available upon request or at least annually:

(1) A list of the names and locations of all affiliated providers;

(2) A description of the service area or areas within which the pharmacy benefits manager provides prescription services;

(3) A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement;

(4) Notice that the pharmacy benefits manager is subject to regulation by the Insurance Department; and

(5) A prominent notice included within the evidence of coverage which provides the following: "If you have any questions regarding an appeal or grievance concerning the pharmacist services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Insurance Department.". Such notice shall provide the toll-free telephone number, mailing address and electronic mail address of the Insurance Department.

Sec. 8. (NEW) (*Effective October 1, 2003*) (a) The Insurance Department shall adopt regulations, in accordance with chapter 54 of the general statutes, to develop formal investigation and compliance procedures with respect to complaints by plan sponsors, pharmacists or enrollees concerning the failure of a pharmacy benefits manager to comply with the provisions of sections 1 to 7, inclusive, of this act. If the department has reason to believe that there is a violation of sections 1 to 7, inclusive, of this act, the department shall serve upon the manager a statement of the charges and a notice of a hearing to be held at a time and place set forth in the notice, which shall not be less than thirty days after the notice is served. The notice shall require the pharmacy benefits manager to show cause why an order should not be

issued directing the manager to cease and desist from the violation. At such hearing, the pharmacy benefits manager shall have the opportunity to be heard and to show cause why an order should not be issued requiring the pharmacy benefits manager to cease and desist from the violation.

(b) The department, with the advice of the Commission of Pharmacy, may make an examination concerning the quality of services of any pharmacy benefits manager and providers with whom the pharmacy benefits manager has contracts, agreements or other arrangements pursuant to its pharmacy benefit management plan. Such examination may be made as often as the department deems necessary, or at the request of the commission. The pharmacy benefits manager being examined shall pay the cost of the examination.

Sec. 9. (NEW) (*Effective October 1, 2003*) An enrollee in a pharmacy benefit management plan shall have the right to privacy and confidentiality in pharmacy services, except that the enrollee or the enrollee's guardian may expressly waive such right in writing.

Sec. 10. (NEW) (*Effective October 1, 2003*) (a) If a pharmacy benefits manager becomes insolvent or ceases to operate in this state in any assessable year or any year during which licensure is required, the manager shall remain liable for the payment of any assessment for any period in which it operated as a pharmacy benefits manager in this state.

(b) In the event of an insolvency of a pharmacy benefits manager, the Insurance Commissioner may, after notice and a hearing, levy an assessment on pharmacy benefits managers licensed in this state. The Insurance Commissioner shall use the amount of any assessment collected pursuant to this section solely for the benefit of enrollees of the insolvent pharmacy benefits manager.

Sec. 11. Subsection (a) of section 38a-11 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

October 1, 2003):

(a) The commissioner shall demand and receive the following fees: (1) For an annual fee for each license issued to a domestic insurance company, one hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, twenty-five dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, one hundred seventy-five dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand one hundred dollars; (4) for filing any additional paper required by law, fifteen dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, twenty dollars; (6) for each certified copy of a license to a company, twenty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, twenty dollars; (8) for amending a certificate of authority, one hundred dollars; (9) for each license issued to a rating organization, one hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of twenty-five dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents appointments: (A) A filing fee of twenty-five dollars for each request for any agent appointment; (B) a fee of forty dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of twenty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company; (12) with respect to insurance producers: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued; and (C) a fee of forty dollars for each license renewed;

(13) with respect to public adjusters: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; and (B) a fee of one hundred twenty-five dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of forty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of forty dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of thirteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of thirteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred dollars for each license issued; and (C) a fee of one hundred twenty-five dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an

applicant; and (B) a fee of five hundred dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of forty dollars for each license issued or renewed; (19) a fee of thirteen dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, twenty-five dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, five dollars; (C) for filing the annual report, ten dollars; and (D) for filing any additional paper required by law, three dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, four dollars; (B) for each certified copy of permit, two dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, four dollars; (22) with respect to reinsurance intermediaries: A fee of five hundred dollars for each license issued or renewed; (23) with respect to viatical settlement providers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of twenty dollars for each license issued or renewed; (24) with respect to viatical settlement brokers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of twenty dollars for each license issued or renewed; (25) with respect to rental companies, as defined in section 38a-799, a fee of forty dollars for each permit issued or renewed; (26) with respect to pharmacy benefits managers, an application fee of ____ dollars for each license issued or renewed; and **[**(26)**]** (27) with respect to each duplicate license issued a fee of twenty-five dollars for each license issued.

This act shall take effect as follows:	
Section 1	*October 1, 2003*
Sec. 2	*October 1, 2003*
Sec. 3	*October 1, 2003*
Sec. 4	*October 1, 2003*
Sec. 5	*October 1, 2003*
Sec. 6	*October 1, 2003*

Sec. 7	*October 1, 2003*
Sec. 8	*October 1, 2003*
Sec. 9	*October 1, 2003*
Sec. 10	*October 1, 2003*
Sec. 11	*October 1, 2003*

Statement of Purpose:

To regulate persons who offer pharmacy benefit management plans in this state.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]